OVERVIEW

Audit of the Adult Mental Health Division's Management of Contracted Community Services

Report No. 02-06, February 2002

Summary

The Department of Health's Adult Mental Health Division provides outpatient and inpatient mental health services to individuals 18 years of age and older. Outpatient services are provided by state operated mental health centers and by a network of community providers. The division's recent focus on preparing patients for community reintegration has resulted in significant funding increases for community-based services. During FY2000-01, nearly $48 million was designated for outpatient services. This audit assessed the division's compliance with established procurement rules and principles and the adequacy of the division's oversight of contracted mental health services.

We found the division chief was derelict in her duty to properly manage community-based contract services. We reviewed 20 percent of the service contracts that were open during FY1999-2000 or during the first half of FY2000-01 and found millions of dollars were spent without ensuring the maximum purchasing value of public funds. Contracts were awarded to vendors without assuring that all proposals were fairly evaluated and without following specifications set forth in the request for proposals. Moreover, significant modifications changed the contracts' scopes and circumvented the open competition and fairness principles of the procurement code. The director of health, who approved these contract awards and modifications, overlooked these concerns.

We also found that the division has fostered a quid pro quo environment in which personal gain seems to precede the State's interest. A former acting division chief who participated in key selection decisions later benefited from employment arrangements made with those who were either awarded a contract or selected for a position with the division. The former acting division chief also was paid by the University of Hawaii while working for the division, including serving as acting division chief. Furthermore, the current division chief exercised poor judgment in funneling the former acting division chief's consultant fee through an existing contract with a major provider. The former acting division chief retired from state service but throughout 2001 received four three-month exempt temporary appointments from his successor. Also, the division hired a former official of a division contractor who resigned shortly after an investigation was initiated regarding expenditures she charged against a contract with the division. The duties she performed for the division did not match the position description nor did she have the requisite qualifications for her position. These advantageous arrangements result in the appearance of a conflict of interest and possible collusion.

The division also failed to ensure that the $20 million it paid community services providers between July 1999 and December 2000 was spent prudently. The division's failure to uphold its fiduciary duties resulted in incorrect payments to

private providers. Moreover, the untimely reconciliation of reported expenses against budgeted cost figures, inadequate withholding of contract payments pending final settlement, and inappropriate payments made to contractors for unauthorized services all increased the risk of financial loss.

Poor contract monitoring and follow-up placed patients at risk of harm and provided little assurance that taxpayers' dollars were well spent. For example, the division spent nearly $6 million on assertive community treatment (ACT) services between July 1, 1999 and December 31, 2000 that did not comply with standards established by the National Alliance for the Mentally Ill (NAMI). ACT teams were staffed with individuals who did not have the recommended work experience for the positions they held. The teams also neglected to adequately follow up with patients left in their care. In one case, the team did not meet with a patient for over two months, even though the provider's standards required teams to meet with patients at least twice weekly.

We also found providers may have cared for patients at unlicensed special treatment facilities. The department's Office of Health Care Assurance (OHCA) and the Department of Human Services' Adult Intake and Protective Services Unit both confirmed allegations of residents being placed at risk of harm at these facilities. However, the department obstructed OHCA's investigation and the facilities in question were allowed to continue providing services to patients.

Recommendations and Response

We recommended that the director of health take immediate action to address the division's contracting deficiencies, including developing internal policies and procedures to guide and improve the procurement process. We also recommended that the director ensure the quality and cost-efficiency of contracted mental health services. In addition we recommended that the governor require the director to review and justify all personal service contracts with former employees that give the appearance of cronyism, conflict of interest, and favorable treatment. Finally, we recommended that the division chief improve the stewardship of state funds and property related to contracted mental health services, and that the Legislature consider transferring the functions of the Office of Health Care Assurance from the Department of Health to another state agency.

The department generally agreed with our audit recommendations. However, it failed to specifically address our audit findings, only to challenge or provide background information on some of our assertions.

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